

Depression Progress Notes: Examples, Templates & Format Guide

Your client just left after a session that covered a lot of ground — a disclosure about passive suicidal ideation early in the week, a shift in mood after some behavioral activation work, and a real moment of insight near the end. Now you need to put all of that into a progress note that's clinically accurate, payer-compliant, and written in the next 20 minutes before your next client arrives.

Depression documentation is some of the most consequential clinical writing you do. It tracks symptom severity over time, justifies continued care to insurers, documents safety assessments, and creates the legal record of your clinical decision-making. Done well, it protects your client and your license. Done vaguely, it creates risk on both fronts.

This guide gives you real examples in SOAP and DAP formats, a printable template, a format comparison table, and a clear breakdown of what strong depression documentation actually looks like.

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Why Depression Documentation Requires Extra Care

Depression is the most commonly treated condition in outpatient mental health settings in the USA. It's also one of the most closely scrutinized by payers during utilization reviews. Insurers want to see documented evidence of symptom severity, specific interventions, and measurable progress or clinical justification for why progress is slow.

Beyond billing, depression documentation carries an additional layer of clinical and legal weight because of safety. Any session where suicidal ideation is present even passive, even denied needs to be documented precisely. What was reported, how it was assessed, what safety planning occurred, and what follow-up was arranged. Incomplete documentation of a safety assessment is one of the most common factors in adverse licensing board outcomes.

Well-structured depression progress notes do four things:

Demonstrate medical necessity for continued treatment

Provide a longitudinal record of symptom change across sessions

Support continuity of care if the client transfers to another provider

Create a defensible clinical record in the event of audit, complaint, or legal review

Key Elements to Document in Every Session

Regardless of which note format you use, these elements should appear in every depression progress note:

Current symptom severity

Use a standardized measure (PHQ-9, BDI-II, or HAMD) where possible. A numeric score gives you something concrete to track over time. At minimum, document a self-reported severity rating.

Specific depressive symptoms

Don't write "depressed mood." Write: persistent low mood rated 7/10, anhedonia, sleep disruption averaging 4–5 hours/night, fatigue, difficulty concentrating, and social withdrawal. Specificity is what demonstrates clinical depth.

Suicidal ideation screening

Every session, every note. Document whether SI was denied, passive, or active. If SI is present, document the assessment approach, content of any safety planning, and what follow-up was arranged. If denied, write "client denied suicidal ideation" explicitly — absence of documentation is not the same as absence of risk.

Interventions used

Name the specific technique and describe how it was applied in this session, not just the modality.

Client engagement and response

Affect, engagement level, in-session emotional shifts, completion of exercises, resistance, and any clinical observations.

Plan

Next session goals, homework assigned, crisis resources provided if relevant, and next appointment date.

Progress Note Formats for Depression

Four formats are commonly used for depression documentation. The right choice depends on your practice setting and payer requirements:

Format	Best For	Depression Strength	Limitation
SOAP	Integrated care, psychiatry, medical teams	Formal Assessment section supports diagnostic clarity	Can feel lengthy for solo outpatient work
DAP	Outpatient individual therapy, fast workflows	Concise; Assessment links symptoms to clinical picture	Less granular on intervention specifics
BIRP	Behavioral health, managed care	Response section directly documents symptom change	Less emphasis on treatment plan goal tracking
GIRP	Goal-monitored settings, managed care	Goal section ties each session to treatment plan	Requires well-written treatment plan goals to work well

For most outpatient therapists in solo or small group practice, SOAP and DAP are the most common. BIRP works well when you want to explicitly track how the client is responding to interventions session over session. GIRP is the strongest choice if your treatment plan goals are well-written and managed care compliance is a priority.

Depression Progress Note Examples

EXAMPLE 1: SOAP FORMAT

Client: Adult, Major Depressive Disorder, Recurrent — Session 7

SUBJECTIVE

Client reported continued low mood, rating the past week 4/10 overall. Stated, "I haven't felt motivated to do anything in weeks." Endorsed persistent fatigue, anhedonia, and disrupted sleep averaging 4-5 hours per night. Reported missing two days of work due to inability to get out of bed. Client denied current suicidal ideation and denied any plan or intent. PHQ-9 score: 16 (moderately severe depression).

OBJECTIVE

Client presented appearing fatigued; affect flat and restricted throughout most of session, with brief brightening when discussing an interaction with a close friend. Eye contact was minimal initially, improving over the course of the session. Speech was slow with reduced spontaneity. Client arrived on time and remained engaged for the full 50-minute session.

ASSESSMENT

Client continues to meet criteria for Major Depressive Disorder, Recurrent, Moderate to Severe (F33.1). PHQ-9 score of 16 represents no change from last session (16), suggesting current treatment approach requires adjustment. Behavioral inactivity and sleep disruption remain priority intervention targets. Social isolation emerging as a secondary concern. No acute safety concerns identified. Therapeutic alliance remains strong.

PLAN

Continue weekly individual therapy. Next session: introduce problem-solving techniques for addressing barriers to behavioral activation. Client agreed to track daily mood and one activity per day using the provided worksheet. Sleep hygiene psychoeducation to be revisited in next session. Client instructed to contact 988 Suicide & Crisis Lifeline if suicidal ideation emerges before next appointment. PHQ-9 to be re-administered at next session. Next appointment: [date].

Client: Adult, Major Depressive Disorder with anxious distress — Session 12

DATA

Client arrived 5 minutes late, reporting a 'really bad week.' Disclosed that they did not complete the behavioral activation homework, stating they felt 'too exhausted to even try.' PHQ-9 score: 18 (severe) at session start, up from 15 at last session. Client became tearful when discussing increasing social isolation, stating 'I don't see the point in reaching out anymore.' Client denied suicidal ideation, plan, or intent. No significant changes to medication reported.

ASSESSMENT

Client presents with severe depressive symptoms, representing a symptom escalation from the prior session. Non-completion of behavioral activation homework, combined with reported exhaustion and hopelessness language, suggests task difficulty needs to be reduced and motivational groundwork addressed before next homework assignment. Social withdrawal deepening. No acute safety concerns. Therapeutic alliance remains intact despite session resistance. Clinical consideration: consult with prescribing provider regarding possible medication adjustment given upward trend in PHQ-9 scores.

PLAN

Therapist and client collaboratively identified one small, manageable behavioral activation task: a 10-minute walk on two days before next session. Next session will introduce motivational enhancement strategies and simplified problem-solving techniques for activation barriers. PHQ-9 to be readministered. Therapist will reach out to prescribing psychiatrist regarding recent symptom escalation. Client reminded of crisis resources (988). Next appointment scheduled in one week.

Depression Progress Note Template

Use this as a starting framework and adapt it to your preferred note format. Print it, save it, or use it as a prompt when building your documentation in your EHR.

Field	What to Include
Symptoms Reported	List specific depressive symptoms in the client's own words where possible (e.g., "I can't get out of bed," persistent fatigue, anhedonia, hopelessness, appetite changes)
PHQ-9 / Severity Rating	Score and clinical interpretation (e.g., "PHQ-9: 14 — Moderate depression")
Suicidal Ideation Screening	Denied / Passive ideation without intent / Active ideation — with specific detail if present. Document outcome of any safety planning.
Affect / Presentation	Observable presentation during session (e.g., tearful, flat affect, minimal eye contact, appeared fatigued)
Interventions Used	Specific technique + how it was applied (e.g., "Behavioral activation: client identified two scheduled activities for the week")
Client Response	Engagement level, emotional shifts, insight, resistance, completion of in-session tasks
Plan	Next session goals, homework assigned, referrals made, crisis resources provided if applicable, next appointment date

 **A note on suicidal ideation documentation:** This field is non-negotiable in every session note for a client presenting with depression. Even when SI is denied, document it explicitly. Boards and courts do not accept the absence of a denial as equivalent to a denial.

Common Documentation Mistakes (and How to Fix Them)

-  **Missing suicidal ideation screening**

This is the highest-risk omission in depression documentation. Every session note should explicitly document the SI screen outcome, even when negative. "Client denied suicidal ideation, plan, or intent" takes 10 seconds to write and creates a critical legal and clinical record.
-  **Vague symptom descriptions**

"Client seemed sad" is not clinical documentation. Write: "Client rated mood 3/10; affect flat and tearful; endorsed persistent hopelessness and passive withdrawal from social activities." Observable and specific.
-  **Interventions not connected to treatment goals**

If you spent 30 minutes on behavioral activation but your treatment plan goal was improving coping skills for depressive symptoms, make that connection explicit in the note. Payers look for this thread.
-  **Omitting standardized measures**

PHQ-9 takes 2 minutes. BDI-II takes 5. These scores do three things: give you objective symptom tracking, support medical necessity documentation, and provide a clear clinical record if outcomes are ever reviewed. Use them consistently.
-  **Copy-paste documentation**

Copying a prior session note and changing the date is an audit red flag and a clinical risk. Depression presentations shift week to week — document what actually happened in this session.
-  **No crisis resources documented**

For clients with depression, every note should reference crisis resources if there is any safety concern, and best practice is to document that resources were provided even when SI is denied. "Client instructed to contact 988 if suicidal ideation emerges" takes one line.

How AI Can Write Your Depression Progress Notes

Writing a complete, individualized depression progress note takes most clinicians 15–30 minutes. Across a full caseload, that adds up to hours of documentation every week most of it after hours, when cognitive load is highest and the risk of vague or incomplete notes is greatest.

AI-assisted documentation tools like [Supanote](#) are built specifically to address this. After a session, you provide Supanote with a verbal summary describing the client's presentation, what interventions you used, and how they responded and the AI generates a structured progress note in your chosen format in under a minute. You review, edit, and finalize.



What AI Handles Well for Depression Notes

What AI handles well for depression notes:

- Structuring your session summary into a clean SOAP, DAP, BIRP, or GIRP format
- Applying consistent clinical language to symptom descriptions across sessions
- Flagging when required fields (SI documentation, plan) are missing or underdeveloped
- Maintaining note structure that aligns with managed care documentation requirements
- Dramatically reducing after-hours documentation time

Where your clinical judgment remains essential:

- AI cannot replicate your clinical assessment. The PHQ-9 score, your read of affect and risk, the nuance of what the client actually said — these need to come from you. Give Supanote specific input, and it produces a specific note.
- Safety documentation is always yours. AI will prompt you to address the suicidal ideation field, but the content, the assessment, and the clinical decision-making are yours to document.
- Diagnostic impressions and treatment direction reflect your professional judgment. AI structures what you tell it. It doesn't formulate.

Supanote is HIPAA-compliant with a signed BAA, supports SOAP, DAP, BIRP, GIRP, and PIRP formats, and is built for mental health providers in private practice and group clinic settings. The free plan lets you start generating notes immediately.

[Try Supanote Free — Cut Depression Note Time by 70% →](#)